NORTH ARLINGTON PUBLIC SCHOOLS

MEDICAL & EMERGENCY CONTACT FORM

STUDENT ID #	DATE OF BIRTH		GENDER	NATIONALITY
LAST NAME	FIRST	INITIAL	SCHOOL	GRADE
ADDRESS				
CITY		STATE		

To Parent or Guardian:To serve your child of accident or sudden illness, it is necessary that you give the following information for emergency calls:

PARENT 1	PARENT 2
ADDRESS	ADDRESS
HOME PHONE	WORK PHONE
PLACE OF EMPLOYMENT	PLACE OF EMPLOYMENT
CELL PHONE	CELL PHONE
CAN PICK UP CHILD FROM SCHOOL? YES ☐ NO ☐	CAN PICK UP CHILD FROM SCHOOL? YES ☐ NO ☐
LANGUAGE (other than English) SPOKEN AT HOME	LANGUAGE (other than English) SPOKEN AT HOME

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

NAME	NAME
ADDRESS	ADDRESS
HOME PHONE	HOME PHONE
WORK PHONE	WORK PHONE
CELL PHONE	CELL PHONE
RELATIONSHIP	RELATIONSHIP
CAN PICK UP CHILD FROM SCHOOL? YES ☐ NO ☐	CAN PICK UP CHILD FROM SCHOOL? YES ☐ NO ☐

Please list other children attending New Jersey Public Schools (Child's Name, Name of School)

HEALTH INSURANCE

Is your child covered by health insurance? YES ❑ NO ❑ **NAME OF HEALTH INSURANCE:**

ONLY COMPLETE THE NJ FAMILYCARE SECTION IF YOU ANSWERED "NO" TO THE HEALTH INSURANCE QUESTION, AND ONLY IF YOU ALLOW US TO RELEASE YOUR CONTACT INFORMATION AS INDICATED.

NJ FAMILYCARE

NJ FamilyCare provides free or low-cost health insurance for uninsured children and certain low-income parents. For more information, call 1-800-701-0710 or visit www.njfamilycare.org to apply.

For your convenience, we can notify NJ FamilyCare on your behalf. To authorize us to release your information, please read the following statement and sign where indicated:

Because my child does NOT have health insurance, I hereby authorize North Arlington School District to release my contact Information to NJ FamilyCare

Signature: _____ **Printed Name:** _____ **Date:** _____

Written consent required pursuant to 20 U.S.C.§ 1232g(g)(1) and 34 C.F.R.. 99.30(b).

HEALTH CONCERNS

Please circle if your child wears BRACES / GLASSES / CONTACTS / HEARING AIDS

Please explain and provide medical documentation for the following:

Allergies and Reactions

Asthma:	Serious Medical condition(s):	Recent Surger:
Medications:		Restrictions

NAME OF CHILD'S DOCTOR		TEL:
NAME OF CHILD'S DENTIST		TEL:
PREFERRED HOSPITAL	ADDRESS	TEL:

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child.
I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

I _____ give my permission for the release of medical information to staff members. _____
PARENT NAME PRINTED — PARENT SIGNATURE

I _____ give my permission for the North Arlington School district to obtain medical information from my child's doctor. _____
PARENT NAME PRINTED — PARENT SIGNATURE